BEYOND THE WORDS: THE POLITICS OF HEALTH CARE REFORM*

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HOW DO WE introduce reforms in America? The common-sense answer at which political scientists have been hooting for years imagines a rational search for solutions to contemporary problems: a problem arises, policy makers seek solutions, they chose the one that seems best.

Political scientists generally take a different view. Political organizations, they argue, rarely operate so sensibly. For example, instead of searching for solutions to problems, a public official is just as likely to be searching for problems that permit him to employ a favored solution. American public policy is said to be forged in a barely organized anarchy where an almost random amalgam of problems, solutions, institutions, and players drift in and out of the process in no particular order. As a result, the political consequences—our public policies—are erratic and difficult to predict.[1]

This paper aims at a middle ground. My purpose is to map the political terrain in which health system reformers operate. While acknowledging the political flux, I analyze current policy choices within the recurring and predictable dimensions of American reform.

First, I lay out the major problems on the health care agenda, emphasizing the political past and potential future of our troubles. The next section turns to solutions; I argue that American reformers constantly return to the same types of answers and consistently shun others. Section three focuses on what we have done to the institutions that link problems and solutions—private markets and government regulators. Finally, I examine four broad policy alternatives for the 1990s: Pluralism, the code word for advocates of competition; an expansion of Medicaid; what might be described as implicit or covert government programs; and national health insurance—the N words which should not be uttered by liberal proponents. Generally speaking, I expect American health policy to progress through each of these solutions, one at a time, slowly "slouching" toward national health insurance.

*Presented as part of the National Health Policy Seminar *Toward a Health Care Financing Strategy for the Nation* held by the Committee on Medicine in Society of the New York Academy of Medicine from October 1986 to August 1988.

PROBLEMS

Political scientists have long contended that the issues on the political agenda are, in themselves, a political matter. Different interests compete to turn their concerns into national priorities. Naturally, objective conditions (say rising health care costs) set the boundaries of the debate, but the political key is how those conditions are interpreted.[2]

Today the American health policy agenda is especially crowded with dilemmas competing for attention. Perhaps the most important are rising costs, uninsured citizens and accountability for the medical system as a whole. Consider each in turn.

Rising health costs have been a fixture in American health policy for more than two decades. The usual perception is that when Medicare was implemented in 1966, costs began to soar. In fact, costs were already rising. In the five years preceding Medicare health care costs rose 13% as a proportion of Gross National Product while in the five "cost crisis" years that followed they rose 20%.[3] However, before Medicare, policy makers simply interpreted rising costs within the framework of the dominant issue; inflation was one more barrier to access. After Medicare, inflation was suddenly being financed partially through tax revenue, and costs swiftly became the major health policy concern.

Twenty years later costs continue to rise. In 1965 health spending consumed 6% of GNP, in 1975 8.4%, in 1980 9.1%, in 1986, 10.9%. Despite a steady tattoo of cost-containment efforts, the overall rate of growth has not even been slowed. In 1986, for example, costs rose 0.3% of GNP, exactly the average since 1980; the hospital and physician sectors grew at annual rates of 10.2% and 11.9% while general inflation rose just 1.1%. Moreover, the health sector consumes a larger portion of the economy in the United States than in any other member of the Organization for Economic Cooperation and Development (OECD). The nearest competitor is France, 13% lower at 9.4% of Gross Domestic Product (GDP). Between 1982 and 1986 the health sector grew more rapidly in the United States than it did in all but three OECD nations (Finland, Iceland, and Switzerland). In fact, during the past four years most industrialized nations saw a decline in the health sector's portion of their GDP.[4] Such figures suggest the unambiguous failure of American cost control policy. Nevertheless, the entire matter—still a "problem" by any objective measure—has diminished somewhat as a policy issue. Although the United States is spending more and 73% of its citizens label medical fees "unreasonable", cost control has lost its monopoly at the top of the American health care agenda.[5]

The new policy dilemma is the roughly 38 million Americans who have no health insurance. Many of the poor and low wage earners cannot pay for their health care. Their sheer number places enormous pressure on medical providers who treat them. The problem has become visible largely because of programs designed to deal with rising costs.

Until recently Americans dealt with indigent care in two ways. Medicaid paid directly for many poor and near poor patients. Perhaps more important, loose private funding arrangements (partially subsidized by the tax code) permitted providers to treat indigent patients and to shift the costs to their properly insured patients. Public welfare programs were, in effect, backed by an elaborate private network of cross subsidies. In response to the cost problem, however, both public and private payers began restricting reimbursements to providers. States began to cut back their Medicaid programs until, by the mid-1980s, they covered less than 40% of the population under the official poverty line. Worse, such private payers as commerical insurers began to cut back their own payments, jeopardizing traditional cross subsidies for the poor.

For a long time the United States could have it both ways—limited government programs and relatively widespread access to care. For reasons explored in the next section, Americans have always preferred implicit solutions (such as private cross subsidies) to public relief programs (such as Medicaid). The unravelling of the former now places an enormous access problem squarely on the public agenda. Demands for reform come not just from the poor, who often find it difficult to control the policy agenda, but from the more politically weighty medical institutions, which are being pushed into deficit by patients who cannot pay. Solutions to the new problem are complicated by failure to resolve the old one by steadily rising medical costs.

Finally, while the related problems of inflation and indigents dominate contemporary discourse, a host of secondary issues compete for attention: long-term care in an aging society, medical education, prenatal care, the AIDS epidemic, and malpractice suits to a name a few. A large array of changes—mostly designed as cost control devices—have been set into place with little concern for their cumulative effect or their impact on medicine. It is not clear what the American stew of regulatory controls, financial incentives, and reimbursement innovations is adding up to. However, it raises a profound underlying question: who is accountable for American medicine?

Various models of accountability are, of course, available. We can look to government, to citizen planning boards, to large corporate capitalists, to individual consumers or—as is the case in most nations—to the profession itself. However, the United States is trying all the models at once, diffusing responsibility and driving the medical sector in unpredictable, perhaps dangerous, directions. Whatever the cumulative effect, one clear upshot is an enormous encroachment on physician autonomy. The entire range of innovations ultimately share a common ideal: reshaping provider behavior to some murky standard of efficiency. As a result, a vague sense of gloom has developed among many physicians, especially younger ones. The general public seems to concur. Three quarters of them believe that the "health care system requires fundamental change" while only a fifth agree that "it works pretty well."[6] The matter of accountability—which raises such fundamental questions as what kind of medical system we are to have, and the nature of the physicians' role within it—constitutes perhaps the most significant and intensely felt problem lurking just off the contemporary policy agenda. Though it complicates almost all our policy debates, it is a difficult problem to articulate, much less address. And, like the issue of indigent care, it is the kind of problem which the American political system is especially maladroit at reforming. The following section explains why.

SOLUTIONS

Solutions available to American policy makers are comparatively limited and tend to repeat a set of distinctive patterns. These limits flow from a familiar ideology: Americans do not like government. Perhaps because, in Tocqueville's celebrated phrase, Americans "were born free without having to become so," they have traditionally distrusted governmental activity, socialist enterprises, and welfare policies.[7] Each is viewed more as a threat to individual liberty than as a mechanism for the public good. Infused by this wariness of their state, Americans designed a government with relatively weak powers and studded it with checks and balances designed to thwart unwanted actions far more easily than to undertake desired ones. Fragmented political authority—attenuated parties, the separation of political branches, federalism—create barriers to any reform. More generally, there are at least three interrelated consequences for political reformers.

First, since Americans distrust both politics and politicians, they tend to seek solutions that rely on neither. Rather than empower leaders to make political choices (say bargaining over medical prices), they restlessly seek out mechanistic, self-enforcing, automatic solutions that can be set in place without further politics or even self-conscious deliberation. For more than a century, reformers have sought permanent policy fixes. The benign, invisible hand of a properly functioning market is the paradigmatic case. However, markets are only the most often repeated expression of an ideal deeply imbedded in American political culture.

The same ideal animates a broad range of contemporary health care reforms. Whether HMOs, DRGs, capitation, regional health planning, or medical vouchers, all share the progressive aspiration that with a bit of tinkering and a few new incentives the problems of the health care system can be solved without politics. The health care system will, it is imagined, run itself without the intrusion of government regulators making choices sullied by politics. Each policy proposal promises some kind of magic fix.

Second, and relatedly, emphasis on policy gimmicks leads to devaluation of good public administration. If hard choices are to be automatic ones, there is no need to find public officials capable of difficult judgements. The recruitment patterns, social standing, and reward structures of public service all reflect this low priority. The result is both less effective administration and a reliance on implicit or covert solutions.

For example, public administrators are, in effect, empowered to negotiate with hospitals under the technical cover of DRGs. Effective administrators might actually employ the device to make thoughtful choices about which medical services to reward or restrain—essentially setting social values on different services.[8] More often, those values are set by default. In either case, the reality of administrators setting hospital prices is obscured by the politically useful illusion that DRGs are "scientifically" derived. The search for a magic fix results both in less concern about effective administrators and reliance on implicit policy choices. The two consequences are analytically distinct. Competent administrators can expand their scope of authority by making conscious but hidden choices. Nevertheless, burying their deliberations retards development of an effective public service.

Third, distaste for government action is articulated most forcefully in the well known reaction against welfare programs. The United States is, as Rodwin puts it, "commonly regarded as a welfare laggard." European leaders such as Bismark or Lloyd George offered welfare benefits in a bid for working class support; Americans worry more about prompting laziness than promoting loyalty.[9] Despite their relatively large numbers, poor people are unpopular clients for public programs. Social welfare programs that have flourished have been those that mix the less needy into the clientele, for example, social security, disability insurance, Medicare.

Reformers searching for solutions to contemporary American dilemmas are bound by these aspects of American reform: faith in gimmicks, an ascetic's stance toward public administration, a penchant for implicit solutions, and a marked preference for respectable clients. These tendencies shaped past programs, constrain current possibilities, and are likely to characterize the fate of future policies. The next sections trace the evolution of American institutions within this broad ideological rubric. I focus on the popular, admittedly sketchy, distinction between markets and government—settings that respectively elicit the most enthusiasm and the most scepticism in the United States.

INSTITUTIONS: POLITICS AND MARKETS

Solutions must be set in institutions. In the broadest general terms, Americans value private sector competition and are wary of governmental intervention. However, the health care politics of the past two decades have significantly altered both the symbols and the realities associated with these categories. This section examines some of the changes and speculates on the implications for contemporary health care reform.

Markets. Free market competition offers a powerful image and a politically effective solution. Over time, different political interests have infused it with entirely different meanings and advanced it as an answer to all kinds of troubles. I shall argue that the recent difficulties of the market approach changes the politics of health system reform—essentially shifting the action into the government sector.

Originally, free medical markets meant deferring to providers. In effect, the market was a circumlocution for professional autonomy and power. The profession claimed control over both medical practice and health care policy. The frequent invocation of market capitalism did not rule out government action. Rather, a broad range of policy programs which ceded public authority to professional judgments were enacted with the enthusiastic support of provider groups. (Licensure regulations, The Hospital Construction Act, popularly known as Hill Burton, and the National Institutes of Health all illustrate the pattern.) On the other hand, reforms that were perceived as threats to professional autonomy (national health insurance, for instance) were loudly decried as tyrannical, usurpatious, and socialistic. Physicians warned against destruction of free markets as a way to muster political allies against government incursions onto their political and professional turf. In effect, they mobilized precisely the political biases described in the preceding section.

As long as the issue on the political agenda was insuring access to care, deferring to providers was a plausible policy. After all, Americans thought their medicine was the envy of the world—the only problem was seeing to it that everybody shared its benefits. Professionals could claim to know how best to do so. However, the politics of deference ended when Medicare authorized massive public funding with minimal public control. The effort to fit a new kind of program into the old institutional forms swiftly changed the dominant health policy problem from access to cost control.

The new problem promoted revision of the old solution. Deferring to providers was an unlikely way to cut costs. The same free market symbol that the profession had long used in its struggle for autonomy was now turned against it. The free market ideal had a new meaning. Now it was a way to discipline providers, to force them to behave more efficiently. The task, argued the new market advocates, was to tinker with the incentives in the medical system until each actor was responding to the proper cues. Consumers would get incentives to shop for high quality at a low price; payers would also shop for the best deal. Providers would race to win customers. Either they would become more efficient or lose their customers and go broke.[11]

There were many variations of the free market argument. Almost by definition, they evinced the classic characteristics of policy solutions in the United States: they avoided government (and the dead hand of regulatory administration) and instead promised a set of automatic, mechanistic answers that, once set in place, would operate more or less permanently.

Ironically, setting the solution into place was complicated by the same ideology that promoted the solution in the first place. Much of its appeal stemmed from reliance on private initiative rather than public intervention; yet introducing a comprehensive market system required carefully coordinating a wide array of government actions (including HMO regulations, adjustments in the tax law, changes in antitrust policy, and so on). After the Nixon, Ford, and Carter administrations tinkered with these changes on the political margins, the Reagan administration finally appeared to give full head to what was soon known as the competition revolution. Crucially, it did not introduce the many regulatory innovations required to launch a comprehensive competitive effort. Instead, the administration encouraged each health care actor to harness competition in whatever manner it saw fit. A wide range of devices—competitive, quasicompetitive, even noncompetitive—were unleashed on the health care system in the name of free markets and efficiency.

The result was a fierce effort among health care payers to constrain their own costs. Although each took a different fiscal tack, all introduced their efforts with the rhetoric of competition and efficiency. Corporations offered their employees the option of enrolling in HMOs. Many left traditional insurance carriers and self insured; some negotiated special deals with health care providers through Preferred Provider Organizations (PPOs). Blue Cross tried to restrain its own premiums with its highly touted "managed care", then hedged its bets by sponsoring HMOs. Commercial insurers responded with their own cost controlling schemes, in many cases promising lower premiums in exchange for higher patient cost sharing. Medicare introduced its complex DRG price setting scheme as a form of competition. Medicaid and Medicare (Part B) simply froze fees.

Perhaps what is most remarkable about all this activity is the extent to which it failed. Indeed, the competition revolution has exacerbated the major dilemmas of contemporary health care policy.

In the first place, managerial innovations have not controlled costs. As noted above, health care inflation quickened relative to GNP during the Reagan years. Moreover, competition among payers may have contributed to the problem. It has forced enormous administrative costs on health providers. Worse, the very notion of multiple payers may have an inflationary bias. After all, many of their cost control strategies from DRGs to PPOs are simply institutional devices through which payers negotiate with providers—one of the keys to Western European cost control strategies as well. However, Americans undermine the bargaining strategy by establishing a multitude of bargainers in the name of competition and choice. Providers seek to maintain their incomes by shifting costs from the payers most effective at controlling their own costs (notably, Medicare and Medicaid) to those least effective (business corporations have proved notoriously ineffective).[12] In effect, providers are offered a multiplicity of safety valves through which to escape tough cost control programs. Ultimately, many payers, each competing to keep its own costs down, facilitate continued inflationary pressure on everybody's costs.

A second distressing consequence is the rise of the uninsured. This follows logically from the competition among payers whose incentives are to pay as little as possible for their own clients and nothing at all for anybody else. Increased patient cost sharing and declining health care insurance coverage are partially responsible. However, the still more fundamental problem, noted above, is that an elaborate system of cross subsidies is coming to an end. The problem is complicated by increasing fragmentation of the risk pool.

Since a relatively small number of patients consume a large portion of medical resources, the most effective way to reduce payments is not through tough negotiating or efficient managerial devices but, rather, avoiding poorer risks. Incentives for competing payers are clear: pay as little as possible for your own clients, insure the healthiest possible market segment, and, above all, do not bear anybody else's costs. Providers in turn face a corresponding set of incentives: find patients whose payers pay relatively more, shift costs from the payers who pay less to those who pay more, seek less sick patients (who are less costly to treat), and, above all else, avoid nonpayers, who will demolish your reputation for efficiency. Thus, everyone's market incentives are similar: seek the healthy and shun the sick. The result is fast erosion of the medical commons, a destruction of the very notion of community.

What is not yet fully recognized is the enormity of the policy task that confronts us as a result. Americans have traditionally had political trouble converting previously implicit solutions—solved behind the political scene with limited government action and funding—into explicit programs. Now that the old system of hidden cross subsidies has ended, we face the problem of designing programs that will extend some sort of medical coverage to 38 million people. The sheer numbers of the uninsured are staggering. To put them in perspective, the number of Americans without health insurance today is more than twice the size of Medicare's constituency when that program was first implemented.

Throughout the 1970s policy makers looked hopefully to the promises of competition. Here was an efficient, apparently painless solution to the problem of health care costs which fit traditional American ideologies as well as the increasingly conservative temper of the time. By the middle of the 1980s, a raft of new policies had been (not completely honestly) introduced and celebrated as forms of competition. As the troubles of the health care sector worsened and multiplied, the image of an efficient, painless, competitive solution began to vanish. It is becoming clear that Americans will have to solve their medical sector dilemmas without the hidden, automatic, nongovernmental gimmick implicit in the magic of competitive markets.

Government. The difference between health politics in the United States and those in other industrialized nations is usually taken to be a question of financing—Americans don't have national health insurance. There is another, often overlooked difference every bit as important for the politics of reform: the comparative incapacity of American government.

The general reluctance to develop competent public administration has been particularly disabling for health care policies. Negotiating with a well organized, highly interested, highly trained profession requires skill and competence. Relying instead on pluralism, gimmicks, and implicit solutions (honored as choice, competition, and proper incentives) may conform to the American spirit of reform but offers little opportunity to control the medical sector or to manage its problems.

However, as the market solution has declined, American government has slowly developed its capacity for sustained administrative action within the health arena. The progress has been slow, hesitant, obscure, and often contradictory. Nevertheless, what appears, at first blush, to be a random succession of programs can also be interpreted as the government's slow progress from deference to control.[13]

To illustrate the point, consider the evolving political and administrative realities that underlay the major postwar health policies. The Hill Burton Act, for example, included elaborate legislative precautions designed to proscribe any administrative meddling in medicine; the federal government promised financing without controls. Almost 20 years later, Medicare appeared to carry on in the same tradition—the legislation opens with stern prohibitions against any governmental "supervision or control over the practice of medicine." (Social Security Act, 1965, Section 101) However, in this case, Congress protested so loudly precisely because it had broken with a half century of deference and passed the entitlement over the bitter objection of organized medicine. When funding without "supervision or control" proved inflationary, the federal government inched further into the medical sphere. The Peer Review program (PSROs, passed in 1972) appeared to be a timid capitulation to organized medicine in the face of the cost crisis. Although it created local boards mandated to constrain physician practice, the boards were not permitted to use national standards, to collect national data, or to place nonphysicians in decision making roles. On the political surface, the federal government appeared to avoid the prospect of building up its administrative authority or competence. However, the reality was a new albeit timidly asserted mission; for the first time, public agencies were seeking to reverse the practice patterns of the profession, to encourage physicians to do less.[14]

The National Health Planning Act, signed in January 1975, turned the attention of health policy analysts to local boards mandated to write health plans and to oversee capital expenses in medical facilities. The local boards, Health Systems Agencies (HSAs), derived their authority largely from state "Certificate of Need" Laws and they sought legitimacy, not by deferring to physicians but by turning to the public. The policies of these health agencies revolved, in large measure, on the apparently bizarre effort to get citizens "broadly representative" of their communities to constrain capital expenditures. The entire episode still baffles most observers. What was the purpose of asking lay people to face aroused hospital administrators in packed meeting halls and vote whether to grant exceptions to incomprehensible bureaucratic standards that ostensibly forbad more beds or machines? Once again, the federally designed effort seemed to go out of its way to avoid competent national administration. However, something important was happening.

Most observers look at the long, late night HSA meetings and ask the apparently sensible questions: Did the HSAs stick to their tasks and say "no" to providers? Did doing so reduce health care costs? The answers are occasionally and no. But they are the wrong questions. What is important about those late night meetings is not that the providers usually won but that they had to argue their case before lay people in the first place. Those arguments took place in communities across the country. They broke the long tradition of deferring medical matters to medical providers. In many communities, new constituents—community leaders, businessmen, public officials—continued to play active roles in medical politics even though the health agencies soon faded from the scene. It is no coincidence that the first American laymen to cross the boundaries of professional dominance and cast judgements about medical matters were not public administrators. They were citizens "broadly representative" of the people. New kinds of controversial government action are often introduced by the latter, rarely by the former. In short, reformers nervous about the legitimacy of their reforms have often made progress against American skepticism about the role of government with a call to "the people."[15]

While the Health Agencies did not transform American health politics, they were a critical step in the progress from the deference of Hill Burton to the development of an independent public capacity to shape health policy, even to the point of significantly altering the practice patterns of the profession. To note just a few examples of the programs which soon followed: in a handful of states, public officials set the prices for all hospital services, regardless of payer. In states such as New Jersey and Massachusetts, broad government programs approximate the publicly mandated health insurance schemes that have long been decried as "socialistic." Medicare's hospital reimbursement method (DRGs) was designed to effect the way physicians practice medicine. By the late 1980s federal officials were proposing changes in Medicare physician payment as a mechanism to promote some medical specialties over others.

This is not to deny that governmental health policies remain inchoate and contradictory. Reforms such as those just noted are rarely administered in a fashion to inspire confidence in the American public sector. However, in the larger historical perspective, they are the latest steps in a steady progress away from the deferential politics that once typified American health policy. Governmental capacity has grown on both the state and the national level; so has the range of interventions that the public sector can legitimately attempt (when it finds the political will—no small caveat, of course).[16]

The upshot for reformers, I think is clear, Americans are most comfortable with their market cure; however, a decade of complication has harmed, perhaps ruined, the appealing market image of a simple, painless, democratic solution that can reduce inflation while making providers more responsive without the meddling of government. Even under the Reagan presidency (indeed, especially under Reagan), the government continued a long trend toward assuming a central role in medical policy. The host of new problems created by old policies is likely to continue the trend. Unfortunately, there is a problematic tension between the politically simple and the politically sensible: more gimmicks, hidden solutions, middle class clients, and weak administrators are likely to win approval. Simple, carefully designed administrative programs might be more effective, but they remain politically difficult to win. Tension between the politically possible and programatically sensible remains the central conflict for political reformers as what Victor Fuchs calls the counterrevolution—the backlash against payer reforms—gets under way.[17]

INTO THE 1990S: CONTEMPORARY REFORM PROPOSALS

The following section considers four types of reform proposals in the context of the problems, solutions, and changing institutional frameworks described above. On the surface at least, the reforming task is complicated by shifts in each one of these dimensions.

Health system problems have become interrelated: continuing inflation is now linked to an enormous access problem and relatively widespread anxiety about the rapidly changing nature of the medical sector. Proposals that seek to address one trouble while exacerbating another are apt to be politically unstable and relatively short lived. Moreover, the most facile solution is gone, at least for the moment. Calling for free market competition in health care no longer evokes the same clear, easy, political resonance. At the same time, the role and capacity of the government has continued to evolve. However, the underlying political instincts that led Americans to celebrate the former and doubt the latter remain. Reform proposals continue to embody the faith in automatic solutions, implicit rather than explicit policies, and hostility toward the "undeserving" poor.

Pluralism. A host of different perspectives march under the amorphous banner of pluralism. Essentially, pluralists argue that Americans should keep their options open. Since no obviously correct solutions have emerged, Americans should encourage diversity and experimentation. States can each pursue reforms that fit the local political and medical cultures, thus restoring an old ideal of American states as laboratories, where many different experiments can be tried before policies are thrust on the nation as a whole. At the same time, private payers and entrepreneurs can continue their own efforts to promote efficiency and to cut costs. The key to the pluralist argument is simple: the federal government should avoid any bold new departures; it should avoid constraining future choices; indeed, it would do best by doing nothing at all.

The pluralist view rests on a mix of perceptions and prejudices. It begins with the perception that a systematic effort to introduce market principles has fallen from political favor—tainted by current public and private programs sold as competition. Consequently, current reforms are likely to involve active government. Related prejudices are familiar and reflect all the usual patterns in the American reforming mindset. The pluralists feel a deep and hostile skepticism toward the government, particularly national government. They believe that private sector solutions derived, somehow, from business principles will ultimately work. They constantly refer to the better management and improved efficiency that emanate from corporate benefits officers or for-profit medical enterprises. And they place their faith in the scattershot of largely payer efforts to induce efficiency through such mechanisms as managed care, capitation, or "a new generation of insurance products."[18]

Clearly, the political image of health care competition has been reconstructed once again, and now appears in the call for national government restraint along with private and local initiatives. Many old market images are present: avoid government coercion, maximize free choice and flexibility, seek incentives for efficiency, be pragmatic, trust in business principles. And in deference to the academic proponents of this view, a new argument has attached itself to the list: study the consequences of the many options.

Like the original proponents of free market medicine, this new generation takes comfort in the usual reluctance to press big new government programs when there is no major crisis at hand. And, as the pluralists see it, there is no major crisis in medicine. On balance, they view the pastiche of public and private forces that are currently transforming medicine as a reasonably good thing. Pluralists point out that the length of stay in the nation's hospitals is falling. New medical care settings (even sectors) are proliferating. Ultimately, this perspective is rooted in what might be called a business school faith—all this activity, all this innovation, all these new forms of private sector administration and management must be on balance a good thing.

In fact, I believe that the pluralist view is exactly wrong. Furthermore, it is precisely the mindset that created the current problems in the medical system. First, a multiplicity of public and private regulators are less likely to constrain costs, regardless of their many innovative gimmicks. These devices amount to a host of different ways of negotiating with providers. By opting for a large number of them, Americans invite medical providers to shift costs from more effective regulators to the less effective and from more effectively regulated health care settings to those less carefully constrained. The image of choice is powerful. But the choice in this context is illusory. It is choice among many inefficient efforts to control costs—indeed, they are inefficient precisely because there are so many. As Eli Ginzberg puts it, an "open ended" third party payment system is invariably an inflationary one.[19]

Secondly, the pluralist mode is hard on the poor. In theory, relatively healthy groups that work their way out of the general risk pool stand to profit: the corporations that self insure, the new closed panel medical plans that select a healthier than average population, the insurance company that effectively manages its beneficiaries. However, this leaves a weaker, sicker pool less protected by classic insurance principles. The pluralistic ideal—let each payer worry about its own costs—gives each the same incentive: avoid the weak, the sick, and the poor. Harvey Sapolsky terms it a race to "beggar thy neighbor."[20] These are not unfortunate side effects. They are the direct incentives structured into a health care system which sets aside ideals of community—of a single communal insurance pool—for notions of individualistic competition.

The problem of the poor is made far more complicated by the American view of welfare. Fragmenting the communal pool and exposing the poor creates a situation that is conceptually uncomplicated but politically almost impossible. It requires large public expenditures toward groups who are very unpopular program clients in an era of large budget deficits. The next solution takes up the question directly.

Finally, the pluralist ideal of multiple payers each pursuing efficiency in its own way is apt to make life increasingly miserable in the medical sector itself. Foreign observers are already astonished at the diminished autonomy of American physicians. A wide multiplicity of gimmicks and incentives are now designed to reshape their behavior. Taken individually, most are not yet particularly powerful, but their cumulative effect is another matter. As Vladeck points out, the lack of public financing creates more rather than less invasive regulations, from both public and private sources.[21]

Fixing Medicaid: the rationalist perspective. On the face of it, the sensible solution to the problem of indigent care is expansion of Medicaid. Of course, we could fiddle with many of the details, even change the name, but now that the system of hidden private subsidies has come apart, many thoughtful observers are calling for the public sector to pick up the slack. Indeed, proponents range from liberals horrified at the size of the indigent population to pluralist corporate executives frustrated by inability to avoid the indigent costs shifted to them.

However, in politics the most direct route between two points is often not a straight line. A new national effort in welfare medicine may be good logic but it is poor politics. Before considering how to fix Medicaid, consider why it is broken.

Welfare medicine is difficult to legislate in the United States. And, unlike most other areas—where winning the legislation poses the most political difficulty—welfare medicine is even more difficult to maintain. The poor, as noted above, make a politically unpopular clientele. Their unpopularity is only partially offset by the indirect beneficiaries, the medical profession. When health care costs rise more quickly than general inflation, government officials face a difficult choice. They can spend relatively more on Medicaid, perhaps at the expense of a more popular constituency, or they can cut the program back. The record of the past two decades is unambiguous—officials chose the latter.[22]

These are predictable political consequences as long as medical inflation runs faster than general inflation. In effect, public officials are asked steadily to increase the size of a program aimed at an unpopular constituency. The pressure of deficits, intermittent tax revolts, and competing priorities exacerbates the problem. And Medicaid (even along with Medicare) does not permit public policy makers a large enough lever to control health system costs. The predictable result is a succession of freezes, cuts, and cost control devices that restrict growth of Medicaid programs in the face of medical inflation. Over time, government officials seek to control their own costs and, as a consequence, induce either cost shifting or bad debt.

In short, restoring Medicaid—making it as it should have been made from the start—is an important task and an appealing reform. However, if attempted without a simultaneous and successful assault on general medical inflation, advocates should be prepared for the same painful political treadmill of the past two decades—steady erosion of benefits and beneficiaries in an effort to control program costs.

The political lesson is not a new one. Programs for the poor tend to be poor programs in the United States. The problem is especially exacerbated in an area with a high rate of inflation. Protecting the health care of the poor requires containing the health care costs of everyone else. Public programs aimed only at the poor do not have the leverage with which to do so. Instead, they leave public officials with incentives to cut back the programs to control their own costs—efectively shifting the problems of the poor to providers and private payers. If pluralists think too much about the costs to private payers, many rationalist liberals do not worry about them enough. Reformers will need to think in global health system terms if the reforms they manage to win are to be maintained.

The New Jersey model: semi-implicit, semi-global. The conundrum for reformers is clear: how to address both costs and access in a political system skeptical of government intervention and welfare programs? A third category of contemporary proposals seeks to do so, essentially by tailoring programmatic details to political necessity. One example is the New Jersey model, although all sorts of variations are possible.[23] The key is to focus equally on both the proposed program and its political effects.

In New Jersey public officials used DRGs to set prices for all payers. At the same time they established an uncompensated care pool, essentially taxing each payer (public and private) to assist the hospitals that served the uninsured. Thus, one program addressed both the problems of inflation and indigents.

The crux of the cost containment effort was not DRGs but the introduction of a single negotiator empowered to set prices throughout the system. In effect, this limits cost shifting and provides state officials a reasonably powerful lever against rising costs. Of course, the extent to which they actually use their negotiating leverage is a function of both the will and the skill of state health officials. The related problem of indigent care was addressed, essentially, by taking each hospital's uncompensated care load and dividing it among the major payers very roughly according to their proportion of the total hospital bill. There is plenty of dispute about the merits of the New Jersey system; opponents claim that it stifles innovation, retards new forms of health service delivery, and rewards inefficient management. However, no one doubts its role in assisting, perhaps saving, inner city hospitals that serve the poor.

The details, however, are less important than the political effects. Here is a program that appears incremental, obscure, pragmatic, and technocratic; at the same time, it seems to avoid welfare, administrative interventions, and new taxes. Although none of these impressions is entirely accurate, they are nevertheless crucial. They substantially reduce the political barriers to the reform. Consider the political pieces one at a time.

First, "extending DRGs from Medicare to all payers and factoring the costs of uncompensated care into the prices" is incremental. American policy makers are always wary of bold new policy ventures. American institutions are designed to deflect them. Extending DRGs is an incremental step. It takes a price-setting mechanism in place for one payer and extends it to others.

Second, it sits easily in American reforming traditions. Rather than explicitly empowering public officials to jawbone prices with providers, it offers an apparently scientific, self-equilibrating mechanism designed to force efficiency on the medical sector. Here is a gimmick that "objectively" sets a price; efficient providers do the work for less and make money, the inefficient won't and don't. As noted above, this can be seen as a somewhat devious way to introduce the centrally negotiated prices that characterize many European systems. However, it does so in a thoroughly American fashion. It relies on an efficiency gimmick while avoiding the appearance of active intervention by public administrators.

Third, it does not look like welfare. "Factoring the costs of uncompensated care into DRG prices" hardly sounds like a liberal effort to sneak a free lunch to the poor. On the contrary, the direct beneficiaries are not poor people but the hospitals that serve them. In short, the program establishes a thoroughly respectable institutional client, entitling the poor only in an indirect—and politically obscure—fashion.

Fourth, the program buries much of the tax hike for covering indigents in the premiums of the private sector. Each payer carries a portion of the burden. Although economists are often critical of such "hidden taxes," poor economics often make good politics. No doubt the program's budget projections will annoy economists still further when cost increases in Medicare and Medicaid are offset by projected savings resulting from the all payer system, thus rendering the whole enterprise budget neutral in "the long run."

Finally, the politics of this proposal are obscure. They are difficult to explain, hard to turn into a cause, unlikely to harm a legislative career. Reforms that stay out of the political limelight are more likely to win. This is especially true of reforms directed (albeit indirectly) at the poor. By avoiding broad symbols, the proposal reduces the likelihood of bureaucrat or welfare bashing. Such relative obscurity is a significant political advantage for a program designed to address the twin health sector dilemmas of inflation and poverty.

The model presented here, patterned on the New Jersey case, is just one possibility. The policy proposal does need not turn on DRGs—any other mechanism will do, so long as it is technical, apparently automatic, seems to provide incentives for efficiency, and is reasonably obscure. And while there may be other ways to treat the health care problems of the poor, the trick is to keep it from looking too much like a welfare program. Nor do I mean to propose this as an ideal model; on the contrary, it is full of problems. For example, it focuses only on acute care hospitals, ignoring ambulatory, chronic, and long-term-care settings. Moreover, the complexity of the system may be a political advantage, but it is likely to pose difficulties for both patients and providers.

Still, in the end, I believe that something like this will emerge. The problems of medical inflation and indigents are too pressing to ignore over the long run. Action, when it comes, is likely to be designed for political ease as much as programmatic logic. The key for political reformers and medical leaders is to help to see that these imperatives are balanced. Too much emphasis on political factors results in poorly designed programs; too little emphasis results in irrelevance.

Beyond the N words: the changing politics of national health insurance. Finally, there is national health insurance. Reformers have tried to win this policy, off and on, for 70 years. Their failure is one of the most distinctive features of the American welfare state. Note, however, that the reform itself has evolved, changing to fit new problems and achieve entirely different ends.

Twenty years ago national health insurance was about an egalitarian health care system, "a right to health care." Today, the old reform is infused with a new content. The new national health insurance is about cost control. The medical system, we are told, will remain inflationary until a single, unitary, mechanism is set in place to control the level of resources that we allocate to health care. Now the key to this policy proposal turns on providing American government the institutional capacity to set a global medical budget. Egalitarian outcomes are merely happy side effects.

Advocates make the argument today, not by referring to conceptions of justice, but by comparing American medical inflation to that of other nations. The Canadian health care experience has become a fixture in debates over American health care financing. As Robert Evans has argued, American and Canadian health expenditures were almost identical (as percentage of GNP) until Canada implemented its national health insurance program, known as Medicare. In the 15 intervening years our costs have continued to rise while theirs are more or less level. By 1987 Americans were spending 2% more of their GNP on health care than the Canadians.[24]

The key point is not that the comparative data are beyond dispute. They are not. Rather, it that the dispute over national health insurance now turns on how to control costs effectively. American medicine has no global budgeting mechanism and by far the highest rate of inflation. The new policy question is whether those two matters are related. Does the absence of political mechanisms implicit in national health insurance programs contribute to our continuing inflation? Uwe Reinhardt was answering precisely this question when he told the New York Academy of Medicine: "Americans spend 2% of their gross national product for nothing more than the privilege of making the following statement: we have no national health insurance."[26]

If the foreign comparisons are instructive, then rising costs may eventually drive us in the direction of a government centered health system. Significantly, the usual retort is not that the American system is superior for the additional expenditure. The braggadoccio with which Americans once made international comparisons has melted before the enormous number of uninsured and the pervasive sense of gloom that permeates American health care. Rather, national comparisons are now set aside as misleading in unpredictable ways. After all, argue the skeptics, American institutions, political culture, and regulatory mores are different, even peculiar. Bargaining arrangements that work well in a nation that respects public administration (not to mention polite queues) might be a mess in a nation of bureaucrat bashers (and queue jumpers).

If foreign comparisons are only partially instructive, we need a comparable American industry. Harvey Sapolsky argues that there is an obvious case: the American defense industry.[25] Here is another highly technical industry performing services simultaneously vital and baffling to the laymen. In both cases, we must often rely on the same providers: a few high tech-defense firms, the local hospital. Moreover, we set impossibly conflicting values before producers in both sectors. Health providers are asked to square the circle between high quality, broad access, and low costs; likewise, defense contractors are asked for timeliness, high performance objectives, and low cost. In each case, other values are important enough that costs are apt to spin out of control. However, the two industries are funded differently. Health care relies on "open ended" funding from a variety of public and private sources. Defense is funded—like classic national health insurance schemes—by the government.

The differences in cost experiences are remarkable. Health care, as a percentage of GNP, has continued its steady upward spiral, stopping only for a very occasional year such as 1984. In contrast, defense has been kept under political control. Despite occasional rises (1965–7, 1974–5), it consumed a steadily diminishing portion of the American economy until the Reagan administration. The Reagan defense build-up illustrates the syndrome of government controlled expenditures: a popular politician articulates a new demand for spending; a large increase in funds is allocated; spending rises relative to other national priorities occur; however, the growth soon runs up against competing national goals, programs, and tax resistance; before long, the growth ends. After the growth of the early and mid-1980s, defense spending flattened out and began to decline as a percentage of GNP.

No comparison "proves" anything, but mounting evidence suggests that global budgets are the most likely way to take control of rising sectoral costs. What is most significant in political terms is the growing discussion of just this point. It is not often that Americans look abroad for a policy fix for anything.

Despite these intimations of cost control, few policy entrepreneurs are interested in pushing a proposal defeated as often as this one. Still, at least two political constituencies are apt to fare somewhat better in a Canadian style system—one is obvious, the other not.

First, obviously, are the poor. As I have argued above, current incentives are to avoid sick and poor people. The old national health insurance logic was based on a desire to even out the medical differences among classes. That logic has not changed as class differences have grown. Only the blindest hostility to the public sector would lead to the conclusion that poor Americans would be made worse off by a national health care system. Enfolding the poor into a national Social Security style system is likely to give them better health care and set into place political coalitions to protect their gains. Modeling the American system on that of Canada might very well reduce inflation as it assists the poor.

Second, physicians themselves might find relief in a national system. To be sure, it would likely end the steady transfer of national resources to the medical sector, but it would also end the steady diet of new bureaucratic and economic techniques designed to push and pull American physicians into practicing more "efficiently." Most nations with a fixed medical budget defer to providers as to how to allocate those funds. They do not need to change the practice of medicine because they control total costs more directly. In contrast, Americans abjure budgetary limits and try instead their array of gimmicks—PROs, DRGs, PPOs, and on and on. Ironically, nationally financed medicine is likely to mean more professional autonomy over medical matters. It is, of course, an unlikely political deal. However, American physicians could do far worse than to support a national health plan in exchange for increased autonomy, that is, in exchange for an end to the long series of manipulative policies designed to change the way they practice medicine.

A national health plan might be both popular and effective. It might substantially ameliorate the problems of the health care system described above. However, it is radically at odds with the kinds of solutions which have typified American politics. In the short run, all three of the policies noted above are more likely than this one.

And yet, liberals ought to take heart. If we are still a long way from Harry Truman's ideal, we are nevertheless far closer than we were a decade ago. This is so for two reasons: first, the decline of competition and deregulation as the American panacea. And second, the reconstruction of national health insurance from an avowedly liberal device aiming at equity to a strategy for promoting cost control. Cost control is more politically respectable since its clients are the middle class. Politically savvy liberals will emphasize the evolution. The imperatives of cost control may eventually prove harder to resist than the ideal of equity.

ACKNOWLEDGMENTS

I thank Marvin Lieberman, Leonard Robbins, and Theodor J. Litman for their many contributions to this paper.

NOTES AND REFERENCES

1. For a fresh approach to these classic themes see Kingdon, J.: *Agendas, and Public Policies*. Boston, Little, Brown, 1984.
2. For an extended analysis of the tension between "objective conditions" and political interpretations see Stone, D.A.: *Policy Paradox and Political Reason*. Boston, Little, Brown, 1988.
3. Computed from Wattenberg, B.J.: *The Statistical History of the United States*. New York, Basic Books, 1976, p. 74.
4. American figures from Anderson G. and Erickson, J.E.: National medical care spending. *Health Affairs 6*:96-101, 1987. OECD figures from Schieber, G.: Trends in international health care spending. *Health Affairs 6*:105-12, 1987.
5. Blendon, R. and Drew Altman, D.: Public Opinion and Health Care Costs. In: *Health Care and its Costs*, Schram, C., editor. New York, Norton, 1987. On the other hand, 71% of those who had been treated recently responded that the fees they had been charged were "reasonable."
6. Ibid.
7. De Tocqueville, A.: *Democracy in America*, Lawrence, G., translator. Garden City, N.Y., Doubleday, p. 9. The classic analysis of the American view of government is Hartz, L.: *The Liberal Tradition in America*. New York, Harcourt, Brace and World, 1955. For a recent application to comparative health politics, see Rodwin, V.: American exceptionalism in health politics: the advantages of backwardness. *Med. Care Rev. 44*:119-53, 1987.
8. For a discussion of the implicit value choices in DRG payments see Veatch, R.M.V.: The Implicit Ethics of DRGS. *Seton Hall Conference on the New Jersey All Payer System*, June, 1985. See also Morone, J.A. and Dunham, A.: Slouching to national health insurance, *Yale J. Reg. 64*:101-15, 1988.
9. Rodwin, op. cit., pp. 120-21. On the European uses of welfare benefits, see Starr, P.: *The Social Transformation of American Medicine*. New York, Basic Books, 1982, 237 ff.
10. This was a standard political routine. Real estate interests (against housing legislation), capital (resisting labor), white Southern Democrats (resisting civil rights), the Catholic Church (resisting federal administration reorganization), and the opponents of water fluoridation are among the interests that

used similar arguments. Morone, J.A.:*The Democratic Wish*. New York, Basic Books, 1990, chap. 1.

11. Enthoven, A.: Consumer choice health plan. *N. Engl. J. Med. 298*:650-658, 1978. (part 1) and 709-720, 1978 (part 2). In my opinion, the clearest exposition of the market logic remains McClure, W: The medical system under national health insurance: four models. *J. Health Politics Policy Law 1*:22-68, Spring, 1976.
12. Etheredge, L.: Ethics and the new insurance market. *Inquiry 23*:311, 1986.
13. For an elaboration of the themes in this section, see Morone, *op. cit.*, chapter 8.
14. On Hill-Burton, see Thompson, F.: *Health Politics and the Bureaucracy*. Cambridge, MA, MIT Press, 1981, chap. 2. On Medicare see Marmor, T.R.: *The Politics of Medicare*. New York, Aldine, 1973.
15. Morone. op. cit., chap. 8.
16. The point is deftly illustrated for Congressional Politics in Brown, L.: The new activism: Federal health politics revisited. *Bull. N.Y. Acad. Med. 66*:294-317, 1990.
17. Fuchs, V.: The counterrevolution in health care financing. *N. Engl. J. Med. 316*:18, 1987, 1154 ff.
18. The press is full of rather double-edged reports which explain why the latest "products" will succeed where the previous efforts failed. See, for example, Honeywell: Push to track doctors. *New York Times*, February 23, 1988, p. D2. See also Boland: Trends in second generation PPOs. *Health Affairs 6*:75-81, 1987.
19. Ginzberg, E., A hard look at cost containment. *N. Engl. J. Med. 316*:1151-54, 1987.
20. The process is nicely described by Harvey Sapolsky (who dubbed the strategy "a race to beggar thy neighbor." An evaluation of the New Jersey DRG Hospital Payment System," *N. J. Med. 85,* 32-37, 1988.
21. Vladeck, B.: America's hospitals: What's right and what could be better? *Health Affairs 5*:100-07, 1986.
22. Etheredge, op. cit., p. 310.
23. The argument here follows Morone, J.A. and Dunham, A.: Slouching to National Health Insurance. For more detail on the New Jersey case, see Dunham, A. and Morone, J.A., *The Politics of Innovation*. Princeton, N.J., HRET Press, 1983; Sapolsky, H.: *An Evaluation of the New Jersey DRG System*; Windman, M. and Light, P.: *Regulating Perspective Payment*. Ann Arbor, MI, Health Administration Press Perspectives, 1988.
24. Evans, R.: *Strained Mercy*. Toronto, Butterworths, 1984; Finding the levers, finding the courage: lessons from cost containment in North America. *J. Health Politics Policy Law 11*:585-615, 1986. Evans et al. Controlling health expenditure the Canadian reality. *N. Engl. J. Med. 320*:571-77, 1989.
25. Sapolsky, H.: Prospective payment in perspective. *J. Health Politics Policy Law 11*:640-42, 1986.
26. Evans, R. et al.: Controlling health expenditures—the Canadian reality. *N. Engl. J. Med. 320*:571-77, 1989.